First Health Services of Montana
DISCHARGE FORM
Notification of Discharge from Services

First Health Services of Montana

To transmit information:
FAX: 1-800-639-8982
PHONE: 1-800-770-3084

Mail: 4300 Cox Road
Glen Allen, VA 23060

Please check the service from which the individual was discharged:

_____ Acute Inpatient
_____ Residential Treatment Center
_____ Therapeutic Group Care (Moderate _____ Intensive _____ Campus Based _____)
_____ Therapeutic Family Care (Moderate _____ Permanency _____)
_____ Partial Hospitalization
_____ Crisis Stabilization

Please type or print:

CLIENT INFORMATION:		
SSN:	**DOB:**	
Name of client: **Last**	**First**:	**Middle**:
Mailing Address:		**City:**
County:	**State:**	**Zip:**
Medicaid/MHSP No.:		

PROVIDER INFORMATION:		
Name of Provider:		
Name of person submitting form: **Last:**	**First:**	**Title:**
Phone No.: ( )		
Today's Date: / /	**(month/day/year)**	
Client discharged to: (i.e., home, another level of service)		
Date of Admission: / /	**(month/day/year)**	
Date of Discharge: / /	**(month/day/year)**	

Discharge Instructions/Plans:

Processing may be delayed if information submitted is <u>illegible</u> or <u>incomplete</u>

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Name: Last:_____ First:_____
SSN: _____

Discharge Instructions/Plans cont:

For First Health's Use Only:

Date discharge information received: _____/_____/_____
Caller's name: Last _____ First: _____ Title:_____
Reviewer Signature: _____

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